Fertility Action

appg The All Party Parliamentary Group For Fertility

Fertility Access in the UK

The Case for a National Fertility Strategy

A policy report on access, diagnosis, treatment and patient support

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Fertility Action is a registered charity in England and Wales (charity no. 1212260).

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Foreword

By Kate Osborne MP

For too many people across the UK, the journey to parenthood is made harder by a system that is inconsistent, difficult to navigate and too often determined by where they live and what they can afford. This report shines an important light on those inequalities and makes a compelling case for change.

Infertility can have a profound emotional, physical and financial impact on individuals and couples. The uncertainty, the waiting and the disappointment can be incredibly difficult to navigate, particularly when people are also faced with restrictive eligibility criteria or the prospect of paying privately for treatment that is simply beyond their means.

Access to fertility care should be fair, transparent and based on clinical need. It cannot be right that a person's postcode, relationship status, sexual orientation or financial circumstances can determine whether they have a realistic opportunity to access treatment. Nor should patients be left to navigate a fragmented system without clear information, timely diagnosis or appropriate emotional support.

This report sets out a practical and important agenda for addressing these inequalities. A National Fertility Strategy would provide the opportunity to establish consistent minimum standards, improve diagnostic pathways, strengthen patient support and ensure that decisions about access are transparent and accountable. It would also help ensure that fertility preservation receives the attention it deserves, particularly for people facing medical treatment that may affect their future fertility.

Crucially, meaningful reform must be shaped by the people who experience these challenges, alongside clinicians, charities and policymakers. Their voices and experiences must be central to developing a system that is compassionate, effective and fair.

I welcome Fertility Action's work in bringing these issues to the forefront of parliamentary discussion. This report provides a timely basis for a serious conversation about what needs to change and how we can work towards a more consistent approach across the UK.

The ability to build a family should not depend on wealth or postcode. It is time to turn the evidence and recommendations set out in this report into meaningful action.

Kate Osborne MP



About Fertility Action

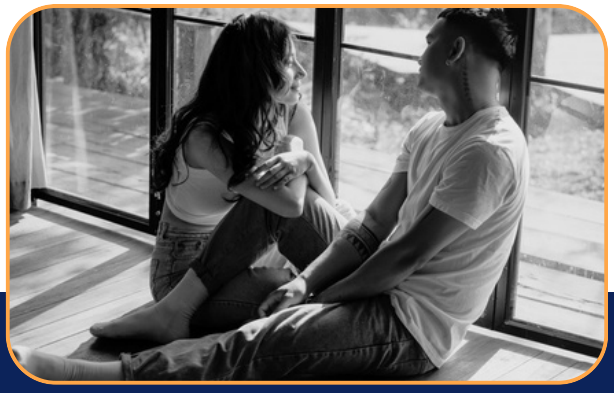
Fertility Action is a national charity providing support, education and advocacy for the one in six people affected by fertility problems across the UK. Through its Fertility Access campaign and its role as secretariat to the APPG for Fertility, it brings together patients, clinicians, advocates and policymakers. Our aim is to combine lived experience, clinical evidence and practical policy in the development of a National Fertility Strategy.

Executive Summary

Infertility affects one in six people [1]. The UK has a world-leading fertility regulator, yet whether someone receives NHS treatment depends largely on where they live, their relationship status and whether they can afford to pay. This report calls for a National Fertility Strategy to end that postcode lottery.

The Key Facts

- NICE recommends three full IVF cycles for eligible women under 40. In March 2026, 27 of the 38 English ICBs with a stated policy funded just one [2,3].
- In 2024, only 25% of IVF cycles in England were NHS funded, compared with 54% in Scotland. Across the UK, the NHS share has fallen from 35% to 28% since 2019 [4].
- NICE estimates that funding three cycles across England would cost about £9.7 million a year more [3].
- Local rules can exclude people on grounds of age, weight or a partner's child from a previous relationship. Female same-sex couples and single women may have to pay for donor insemination before they can be referred [5].
- The UK scores 65% on the European Atlas of Fertility Treatment Policies, well behind Belgium (89.5%), the Netherlands (89.4%) and France (85.5%) [6].



What we are asking for

1. A National Fertility Strategy for the UK, with an implementation plan and named accountability in each nation.
2. National minimum access standards in line with NICE, with ICBs required to publish their policies and explain any departure.
3. An independent review of local eligibility criteria for clinical justification, fairness and equality impact.
4. A nurse-led, one-stop diagnostic pathway, piloted and evaluated, so that core tests for both partners are complete before the first specialist appointment.
5. A national fertility access dataset covering referral, waiting times, funding decisions and outcomes.
6. Sustainable funding and workforce planning, with consistent access to fertility preservation and better patient information, psychological support and workplace protection.

1. The Case for a National Fertility Strategy

1.1 Fertility care is healthcare

The World Health Organization defines infertility as a disease of the reproductive system [1]. Yet it is not funded like other conditions. NICE sets out the care patients should receive, but only 3 of the 38 English ICBs with a stated policy fund the three cycles it recommends [3].

Infertility causes real harm: grief, anxiety, depression and relationship strain. Those paying privately may borrow, use their savings or stop treatment because they cannot afford to continue. It also affects work. In a 2025 survey of more than 3,600 employees and employers in five countries, including the UK, 38% of employees said they had left or considered leaving a job because of the challenges of fertility treatment [7].

1.2 Time matters

Fertility declines with age, so delay is never neutral. Every month spent waiting for tests, referral or a funding decision can reduce a patient's chance of success or push them past a local age cut-off. The fertility rate in England and Wales fell again in 2025, to 1.39 children per woman [8]. Treatment alone will not reverse this, but people who want children should not face avoidable barriers to having them.

1.3 Local decisions alone are not enough

In England, each Integrated Care Board (ICB), the local NHS body that plans and pays for services, decides what fertility treatment to fund. NICE sets the clinical standard but cannot require ICBs to follow it. The Human Fertilisation and Embryology Authority (HFEA) regulates clinics but not NHS funding. Nobody is accountable for whether patients can actually get the care NICE recommends.

1.4 It is affordable

NICE puts the NHS cost of a full IVF cycle at £3,764. It estimates that moving the whole of England to three cycles would add about £9.7 million a year [3]. That estimate assumes an average of 1.3 completed cycles per patient and no change in the number of patients treated. A full national costing should also cover diagnostics and workforce. NICE recommendations are based on evidence of clinical and cost effectiveness [2]. The barrier to fair access is not the evidence or the cost. It is the lack of a national framework.



2. What We Are Asking For



2.1 Immediate actions

- Develop a National Fertility Strategy with a published implementation plan, milestones and named accountability in each UK nation.
- Set national minimum standards for assessment, diagnosis, referral and treatment, in line with NICE guideline NG257, including measures of waiting times.
- Require ICBs to publish their fertility policies and report against NICE guidance, explaining any departure from it.
- Commission an independent review of eligibility criteria, including age, BMI, previous children, relationship status, sexual orientation and requirements to self-fund, testing each against evidence, proportionality and equality impact.

2.2 Structural reforms

- Pilot and evaluate a nurse-led, one-stop diagnostic pathway (Section 3)
- Create a national fertility access dataset that builds on HFEA data (Section 6.2)
- Publish a costed funding and workforce plan so that wider access can be delivered safely.

2.3 Patient support and protection

- Create a national patient information resource on tests, treatment, NHS eligibility, private costs and sources of support
- Set a consistent pathway for fertility preservation before cancer treatment, gender-affirming treatment and other treatment that can harm fertility, with fair access to use stored eggs, sperm or embryos later.
- Introduce workplace protections, including a right to reasonable time off for treatment, protection from discrimination and guidance for managers.
- Build psychological support into service standards, rather than treating it as optional.
- Strengthen protection for patients of online fertility providers, including safeguards for patients' money and continuity of care if a provider closes..

2.4 Is it affordable

- Appoint a senior national fertility lead in England, with equivalent arrangements in the devolved nations.
- Establish formal patient representation in policy development and oversight, reflecting the diversity of people affected.
- Publish an annual fertility access report showing progress by region and nation.

3. A Practical First Step: A Nurse-Led One-Stop Diagnostic Pathway

Many patients wait months and attend several appointments before basic tests are complete. Male partners are often tested late, or not at all, before referral. A nurse-led, one-stop pathway would change this.



How it works

A trained fertility nurse, working to agreed protocols, arranges the core tests for both partners before the first specialist appointment. Depending on the patient's history, these may include semen analysis, ovarian reserve testing, a pelvic ultrasound scan, ovulation and thyroid tests and infection screening. The specialist then sees the patient with results in hand and can agree a plan at the first visit.

It is already proven

Most private fertility clinics already work this way.

How it should be introduced

The pathway should be designed with GPs, fertility specialists, laboratories and patients. It should follow NICE recommendations on investigating both partners [2] and include clear escalation for abnormal results and for patients for whom time is critical. It should be piloted and evaluated on time to diagnosis, number of appointments, patient experience, equity and cost.

"It changed my life forever from being happy go lucky and relaxed, upon diagnosis I felt like a complete failure as a man. It's taken me a long time to accept it and to be honest, I still don't feel 'normal' or 'like my old self' sometimes

"Financially, emotionally it's been incredibly tough. I haven't felt truly happy since experiencing these difficulties"

"It's everything you think about from the moment you wake up to the minute you go to sleep. It feels like you're having a nightmare that you can't wake up from. It holds a financial burden over you"

4. The Evidence: A Postcode Lottery

4.1 NICE recommends three cycles; most areas fund one

NICE guideline NG257, published in March 2026, recommends offering three full IVF cycles to eligible women under 40, and considering up to three more if these are unsuccessful. It recommends one full cycle for eligible women aged 40 or 41 who have not had IVF before. A full cycle means one round of ovarian stimulation and the transfer of all the resulting embryos, fresh and frozen [2]. Most ICBs fall well short of this.

Cycles funded by ICB policy	Number of ICBs	Share
One Cycle	27	71%
Two Cycles	8	21%
Three Cycles (NICE Standards)	3	8%

Table 1. NHS-funded IVF cycles by ICB policy in England, March 2026. Based on 38 ICBs with a stated policy; four further policies were under review. Policies may have changed since, including through ICB mergers in 2026. Source: NICE resource impact summary report [3].

UK nation	IVF cycles NHS funded, 2024
England	25%
Wales	35%
Northern Ireland	50%
Scotland	54%
UK overall	**28%** (35% in 2019)

Table 2. Share of IVF cycles that were NHS funded, by nation, 2024. Figures are based on where the clinic is, not where the patient lives, and are not a direct measure of individual eligibility. Source: HFEA [4].

4.2 Restrictive eligibility criteria

Even where treatment is funded, local rules can shut people out [5].

Common criteria include:

- age limits lower than those recommended by NICE;
- BMI limits, sometimes applied without clinical discretion;
- a requirement to have no previous children, which can exclude a woman with no children of her own because her partner has a child from a previous relationship;
- a requirement for female same-sex couples and single women to pay for rounds of donor insemination before they can be referred;
- exclusion of anyone who has already paid for treatment privately.

NICE is clear that previous self-funded IVF should not, by itself, rule out NHS treatment for eligible women under 40 [2]. Each local criterion should be tested for clinical evidence, fairness and equality impact. Because fertility is time-sensitive, policies should also ensure that NHS delays do not push patients past an age cut-off.

4. The Evidence: A Postcode Lottery

"We moved our entire lives up to Bristol because we thought it would give us the chance to access IVF through the NHS. It hadn't even occurred to us to check again because we'd been told that moving could make the difference."



4.3 Waiting times and workforce

Patients can wait at every stage: first assessment, tests, specialist referral and treatment. There is no comparable national measure of these waits across the four nations, and a single headline figure can hide long delays before a patient even joins a specialist list.

Expanding treatment also depends on people: embryologists, fertility nurses, specialists, sonographers and counsellors. A shortage at any point in the pathway causes delay, even where funding exists. Workforce planning must be linked to any expansion in funded treatment.

4.4 The private market

Where NHS treatment is not available, private treatment is the only option, for those who can afford it. Clinics set their own prices, and the same treatment can cost two or three times as much at one clinic as at another [9]. Drugs, frozen embryo transfers, donor eggs or sperm and storage all add to the bill, and many patients need more than one cycle. Travel, time off work and childcare add further cost. The result is a two-tier system based on ability to pay.

Regulation has not kept pace. When the online provider Apricity Fertility closed at short notice in January 2025, the HFEA could not help patients obtain refunds, because online providers fall outside its remit [10]. Bill 4005 would bring such providers under HFEA regulation [11].

4.5 How the UK compares

Country	Atlas score, 2024
Belgium	89.5%
Netherlands	89.4%
France	85.5%
Denmark	75.7%
Ireland	66.5%
United Kingdom	**65.0%**

Table 3. Scores in the European Atlas of Fertility Treatment Policies 2024, which assesses policy (law, public funding, eligibility and patient support) across 49 countries and territories. Scores do not measure clinical quality or outcomes. Source: Fertility Europe and EPF [6].

The Atlas shows that fair access depends as much on who is eligible, and on the support patients receive, as on the number of funded cycles [6].

5. Who Is Most Affected?



5.1 People on lower incomes

Where NHS treatment is restricted or delayed, people who can pay are treated sooner, and those who cannot may go without. The added costs of travel, appointments and time off work fall hardest on people in less flexible jobs. A national strategy should measure access, waiting times and outcomes by deprivation.



5.2 Black and Asian patients

HFEA data show lower birth rates after fresh embryo transfer for Black and Asian patients than for White patients [12]. The causes are not established. Access, referral, diagnosis and the experience of treatment should be examined with the communities affected.



5.3 LGBTQIA+ people and single people

Many NHS pathways are designed around heterosexual couples. Female same-sex couples and single women may be required to pay for several rounds of donor insemination before NHS treatment is considered [5]. Donor sperm and the associated clinical services add substantially to the cost. Access criteria should be appropriate to different routes to parenthood and should not act as a financial test.



5.4 People whose fertility is threatened by illness or treatment

Cancer treatment, endometriosis, premature ovarian insufficiency and gender-affirming treatment can all affect fertility, often with little time to decide. NICE recommends that the eligibility criteria used for IVF, including the lower age limit, should not be applied to fertility preservation. However, local IVF criteria apply when people later come to use their stored eggs, sperm or embryos [2]. Access to preservation remains inconsistent. A national pathway should cover timely discussion before treatment, preservation, storage, later treatment, and people who could not preserve their fertility in time.

6. Why the Current System Falls Short



6.1 Fragmented responsibility

NICE sets clinical guidance, the HFEA regulates clinics and ICBs decide funding, but no single body is responsible for whether patients can get the care they need. Fragmentation starts before specialist treatment, with tests and referrals coordinated differently between GPs, hospitals and clinics. A national strategy must define who is accountable for access, while respecting the roles of the UK Government, the devolved administrations and NHS bodies.



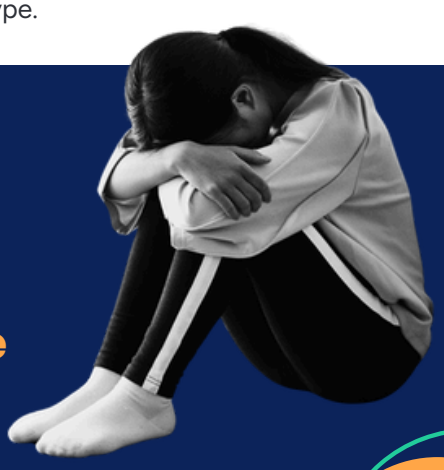
6.2 Gaps in the data

The HFEA register is a major national asset, but it records treatment, not access [4]. Nobody routinely collects data on what happens before treatment, or on why people never receive it. Building on HFEA data, with appropriate privacy safeguards, a national dataset should capture:

- dates of referral and of completed tests, including for male partners;
- local eligibility rules, funding decisions and reasons for ineligibility;
- waiting times from first presentation to the start of treatment;
- access to fertility preservation and later use of stored material;
- outcomes and patient experience, by area, age, ethnicity, deprivation and family type.

"To then find out we'd done it for nothing was heartbreaking.

My husband has been allowed the chance to be a dad, but I haven't been allowed the chance to experience being a mum."



7. Conclusion: A Call to Action



Fertility treatment is healthcare. NICE has set the standard, the cost of meeting it is modest, and the evidence of unfair variation is clear. What is missing is a national framework that makes that standard real for every patient.

The ability to build a family should not depend on postcode or bank balance, nor on relationship status, sexual orientation or ethnicity. Fertility does not discriminate. NHS funding rules should not either.

The time for a National Fertility Strategy is now.



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12. Human Fertilisation and Embryology Authority. Fertility treatment 2023: trends and figures [Internet]. London: HFEA; 2025 Jun [cited 2026 Oct 29]. Available from: https://www.hfea.gov.uk/about-us/publications/research-and-data/fertility-treatment-2023-trends-and-figures/

Further Reading

- Local fertility policies, ICB by ICB: Progress Educational Trust, Fertility Policy Tracker. https://www.progress.org.uk/fertility-policy-tracker/
- The NICE guideline in full: NICE NG257, Fertility problems: assessment and treatment. https://www.nice.org.uk/guidance/ng257
- International comparison: Fertility Europe and EPF, European Atlas of Fertility Treatment Policies 2024. https://fertilityeurope.eu/atlas2024/
- Patient stories: Fertility Action. [Link to be added]
- Costs and economics: NICE NG257 resource impact summary report. https://www.nice.org.uk/guidance/ng257/resources/resource-impact-summary-report-15666154237

Glossary

Term	Definition
APPG (All-Party Parliamentary Group)	An informal cross-party group of MPs and Members of the House of Lords who share an interest in a particular issue. APPGs have no official status within Parliament, and their views do not represent those of either House. The APPG for Fertility brings together parliamentarians concerned with fertility access and policy. Source: UK Parliament, Guide to the Rules on APPGs
BMI (Body Mass Index)	A measure of weight relative to height (kg/m²). Many ICBs use BMI as an eligibility criterion for NHS-funded fertility treatment, with common ranges of 19 to 30 or 19 to 35. Source: NHS; NICE NG257
Commissioning	The process by which NHS services are planned, purchased and monitored. In England, fertility services are commissioned by ICBs, which set local eligibility criteria and decide how many IVF cycles are funded. Source: The King's Fund
Cryopreservation	Freezing and storing eggs, sperm, embryos or reproductive tissue at very low temperatures for future use. Central to fertility preservation. Source: HFEA
DHSC (Department of Health and Social Care)	The UK Government department responsible for health and adult social care policy in England. It publishes data on NHS-funded IVF by ICB. Source: GOV.UK
Donor gametes	Eggs or sperm donated by a third party for use in fertility treatment, including by single people, same-sex couples and people who cannot use their own. Regulated in the UK by the HFEA. Source: HFEA
Embryo	A fertilised egg that has started to develop. In IVF, embryos are created in a laboratory and either transferred to the womb fresh or frozen for later use. Source: HFEA
Embryo transfer	The procedure in which an embryo is placed in the womb. A funded "cycle" and an embryo transfer are not the same measure, which matters when comparing ICB policies. Source: HFEA
Endometriosis	A condition in which tissue similar to the womb lining grows elsewhere, such as on the ovaries and fallopian tubes, causing pain and sometimes fertility problems. Source: HFEA
Fertility Europe	A European umbrella organisation of national fertility patient associations. With the European Parliamentary Forum for Sexual and Reproductive Rights, it produces the European Atlas of Fertility Treatment Policies. Source: Fertility Europe
Fertility preservation	Freezing eggs, sperm, embryos or reproductive tissue so that a person may have a biological family later, for example before cancer treatment. NICE NG257 recommends that IVF eligibility criteria, including the lower age limit, should not be applied to fertility preservation. Local IVF criteria apply when stored material is later used. Source: HFEA; NICE NG257
FET (frozen embryo transfer)	The transfer to the womb of an embryo that was frozen in an earlier cycle. It does not require ovarian stimulation. Source: HFEA
Full IVF cycle	NICE defines a full cycle as one episode of ovarian stimulation and the transfer of all resulting fresh and frozen embryos. A funded "cycle" in local policy may mean a full cycle or a single transfer. Source: NICE NG257
Gamete	A reproductive cell: an egg or a sperm. Source: HFEA
Gender-affirming treatment	Medical treatment, including hormone therapy and surgery, undertaken as part of gender transition. Some treatments can affect fertility, making preservation an important consideration beforehand. Source: NHS England; NICE NG257
HFEA (Human Fertilisation and Embryology Authority)	The UK's independent regulator of fertility treatment and human embryo research. It licenses and inspects clinics, holds the national register of treatment and publishes annual data. It does not decide NHS funding. Source: HFEA

Glossary

Term	Definition
ICB (Integrated Care Board)	The statutory NHS body that plans and commissions health services for a local area in England. ICBs replaced Clinical Commissioning Groups in July 2022. Each sets its own fertility policy. Source: Health and Care Act 2022
ICSI (intracytoplasmic sperm injection)	A form of IVF in which a single sperm is injected directly into an egg, used mainly when sperm quality or quantity is low. Source: HFEA
Infertility	A disease of the male or female reproductive system, defined as failure to achieve a pregnancy after 12 months or more of regular unprotected intercourse. The WHO estimates that about one in six people experience infertility in their lifetime. Source: WHO
IUI (intrauterine insemination)	A treatment in which prepared sperm are placed directly into the womb around the time of ovulation. Also called artificial insemination. Some ICBs require female same-sex couples to have several rounds before NHS-funded IVF. Source: HFEA
IVF (in vitro fertilisation)	Treatment in which eggs are collected and fertilised with sperm in a laboratory, and the resulting embryo is placed in the womb. Source: HFEA
Male-factor infertility	Infertility caused wholly or partly by problems with sperm production, quality or delivery. It is often investigated late. NICE NG257 recommends investigating both partners. Source: HFEA; NICE NG257
NG257	The NICE guideline on fertility problems, published 31 March 2026, replacing CG156 (2013). It recommends three full IVF cycles for eligible women under 40 and one for eligible women aged 40 or 41. Source: NICE
NHS-funded cycle	A fertility treatment cycle paid for by the NHS. In 2024, 28% of IVF cycles in the UK were NHS funded, ranging from 25% in England to 54% in Scotland. Source: HFEA
NICE (National Institute for Health and Care Excellence)	The independent body that issues evidence-based guidance for health and care in England. NICE guidance informs, but does not require, local funding decisions. Source: NICE
Ovarian reserve	An estimate of the number of eggs remaining in the ovaries, usually assessed by an AMH blood test and an ultrasound count of follicles. Source: HFEA
Ovarian stimulation	The use of hormone medication to make the ovaries produce several eggs in one cycle. It is the first step of most IVF cycles. Source: HFEA
PET (Progress Educational Trust)	A UK charity that informs public debate on genetics and assisted reproduction. It publishes BioNews and the Fertility Policy Tracker, which shows IVF funding by ICB. Source: PET
POI (premature ovarian insufficiency)	A condition in which the ovaries stop working normally before the age of 40, reducing or ending fertility. Source: Daisy Network
Postcode lottery	Variation in NHS services depending on where a patient lives. In fertility care, it describes differences between ICBs in funded cycles, eligibility rules and waiting times. Source: common policy usage
Primary care	Care from GPs, practice nurses and other community clinicians: usually the first point of contact for people with fertility concerns. Source: NHS England
Semen analysis	A laboratory test of sperm count, movement, shape and volume. A baseline test in assessing male fertility. Source: NICE NG257; WHO
Total fertility rate	The average number of children a woman would have over her lifetime if current birth rates by age continued. The ONS reported 1.39 for England and Wales in 2025, down from 1.41 in 2024. Source: ONS
Two-tier system	A system in which access to treatment depends on ability to pay. In fertility care, people who cannot get NHS treatment must pay privately or go without. Source: common policy usage

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